STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155233	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 29, 30, 31, September 1, and 2, 2011 Facility number: 000138 Provider number: 155233 AIM number: 100266500 Survey team: Diana Sidell RN, TC Penny Marlatt RN Janie Faulkner RN Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 2 Medicaid: 55 Other: 22 Total: 79 Sample: 16 Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Preperation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 9/9/11 Cathy Emswiller RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the	F0157	**F157 Notify of Changes:** It is	09/25/2011

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	facility failed to notify a resident's physician of recommendations from the Registered Pharmacist's monthly pharmacy regimen review in a timely manner. This deficient practice affected 1 of 9 residents reviewed for psychotropic medications in a sample of 16. (Resident #7) Findings include: Resident #7's clinical record was reviewed on 8-30-11 at 10:22 a.m. His diagnoses included, but were not limited to dementia, middle cerebral artery cerebrovascular accident (stroke), hypertension (high blood pressure), depression and anxiety. Review of a document entitled, "Consultation Report," dated 6-9-11, indicated the facility's pharmaceutical services recommended, "Please consider monitoring a fasting lipid panel [lab test for blood fats], ALT [lab test for liver function] and a BMP [lab test for basic metabolic elements] on the next convenient lab day and at least every twelve months thereafter." Review of the clinical record since the date of the recommendation failed to indicate the recommendation had been forwarded to the resident's physician for review and failed to indicate these laboratory tests		the intent of this facility to notify the Resident's Physician of all pharmacy recommendations in a timely manner. **1. ACTIONS TAKEN:** A. In regards to resident # 7, the recommended labs were drawn and an order received for them to be repeated annually. **2. OTHERS IDENTIFIED:** A. 100 % audit of all residents pharmacy recommendations for the last three months. No other issues were identified. **3. MEASURES TAKEN:** A. In service for all licensed nurses on notifying the physicians in a timely manner, and appropriate follow-up, of all pharmacy recommendations. **4. HOW MONITORED:** A. D.O.N./designee to review all pharmacy recommendations and notify physician within one week of receiving the recommendations. This will be an on-going process. B. DON/Designee to follow-up/audit in one week of notifying the physician for response to pharmacy recommendations. This will be an on-going process. C. CEO/Designee will review all audits monthly with QA team and quarterly with Medical Director in QA meeting. **5. DATE COMPLETED:** This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. **Our date of compliance is September 25, 2011.** .	

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	had been conducted. In interview with the Director of Nursing on 9-2-11 at 9:35 a.m., he indicated he had yet to forward the recommendations to the physician. This would be almost 2 months, 54 days, after the recommendation was made by the pharmacist. In interview with the Assistant Director of Nursing on 9-2-11 at 10:50 a.m., she indicated, "I would have thought the labs should have been able to be gotten at the next scheduled lab day. The lab comes once a week for non-emergency or stat labs. For a stat lab they can come right away." A policy entitled, " Consultant Pharmacist Responsibilities, " with a revision date of 12-1-06, was provided by the Director of Nursing on 9-2-11 at 12:03 p.m. This policy indicated, " The consultant pharmacist shall be responsible for the general supervision of the facility ' s pharmaceutical services. These responsibilities include, but are not limited to ...Drug Regimen reviews for all residents as required ...This Drug Regimen Review report must be forwarded by the facility to the appropriate physician. The physician must provide a written response to the			

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	facility in a timely manner ... " 3.1-5(a)(3)			
F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop comprehensive care plans that met residents needs in that 1 resident failed to have a care plan that addressed anticoagulant (suppresses blood clotting) use (Resident #37), and 3 residents failed to have care plans that addressed use of psychotropic	F0279	**F279 Develop Comprehensive Care Plans** The intent of this facility is to develop a care plan for all residents' receiving anticoagulant medications and use of psychotropic medications. **Actions Taken:** In regards to Residents # 37: A care plan was developed that addressed the potential side effects and the monitoring of labs	10/02/2011

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	medications. (Residents #14, 7, and 32) This affected 4 of 13 residents reviewed for comprehensive care plans in a sample of 16. Findings include: 1. Resident # 37's record was reviewed on 9/1/11 at 2:45 p.m. The record indicated Resident #37 was admitted with diagnoses that included, but were not limited to, atrial fibrillation (heart arrhythmia), coronary artery disease, prior heart attack, chronic low blood pressure, and aortic stenos. A History and Physical dated 6/6/11 indicated, but was not limited to; "...On chronic Coumadin (anticoagulant) therapy for the atrial fibrillation...." Physician's recapitulation orders dated August 2011 indicated an order for Coumadin, 4 milligrams by mouth every day, with a start date of 7/27/11, and an order to recheck lab work for a PT/INR (Prothrombin Time/International Normalized Ratio) in one week. Review of care plans with a last review date of 7/18/11 indicated Resident #37 failed to have a care plan for Coumadin that addressed potential side effects and		for Coumadin therapy. In regards to Resident # 14: a care plan was developed that addressed the use of Seroquel and Zoloft for potential side effects and monitoring. In regards to Resident # 37: A care plan was developed for Zyprexa, Seroquel, and Celexa; appropriate diagnosis for each, including potential side effects and monitoring. In regards to Resident # 32: a care plan was developed for the use of Valium, Ambien, and Zoloft with an appropriate diagnosis; and including potential side effects and monitoring. **Others Identified:** 100% audit of all residents for use of anticoagulant medications and antipsychotropic medications; audit for an appropriate care plan which includes diagnosis, potential side effects, and monitoring. All residents identified will have their care plan updated/revised. **Measures Taken:** Nursing staff/Social Services were in-serviced on, in regards to initiating care plans for all residents' who receive anticoagulant and/or antipsychotropic medications to include an appropriate diagnosis, potential side effects, and monitoring. **How it will be monitored:**	

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	monitoring such as labs. A care plan for Coumadin use was requested on 9/2/11 at 11:00 a.m. and RN #1 indicated "if we don't have one [care plan for Coumadin use], we will get one on her chart." A care plan was not provided after this request as of exit on 9/2/11. 2. Resident #14's record was reviewed on 8/29/11 at 2:07 p.m. The record indicated Resident #14 was admitted with diagnoses that included, but were not limited to, altered mental status, anxiety, depressive disorder, peripheral vascular disorder, Alzheimer's disease, and senile dementia. Physician's recapitulation orders dated August 2011 indicated the following orders for psychotropic medications: - Seroquel 25 milligrams, 1 tablet by mouth twice a day for altered mental status. - Zoloft 100 milligrams by mouth daily for depression/anxiety, with a start date of 7/18/11. Physician's telephone orders dated 7/18/11 indicted this order originally had been 50 milligrams by mouth every day with a start date of 5/18/11.		The IDT will audit/review all care plans quarterly and prn to monitor for appropriate diagnosis for each medication and an appropriate care plan to include potential side effects and monitoring. The CEO/Designee will review all audits of care plans in weekly QA stand-up meeting and in quarterly QA meeting with Medical Director.	

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	Review of care plans with a last review date of 8/29/11 indicated Resident #14 failed to have a care plan for the use of the Seroquel and Zoloft that addressed potential side effects and monitoring. C. Resident #7's clinical record was reviewed on 8-30-11 at 10:22 a.m. His diagnoses included, but were not limited to dementia, middle cerebral artery cerebrovascular accident (stroke), hypertension (high blood pressure), depression and anxiety. A review of Resident #7's medication orders indicated current physician orders for the psychotropic medications of Zyprexa 2.5 mg (milligrams) twice 9:00 a.m. and 9:00 p.m., of Seroquel 50 mg twice daily at 9:00 a.m. and 9:00 p.m., of Seroquel 25 mg daily at bedtime at 9:00 p.m., to be given with Seroquel 50 mg and Celexa 40 mg daily at 9:00 a.m. The Zyprexa was indicated to be used for depression; the Seroquel did not have a specific indication for its use; the Celexa was indicated to be used for depression and anxiety. The "Nursing Spectrum Drug Handbook 2010" (pages 1007-1009) indicated Seroquel is indicated for use in persons with diagnoses of schizophrenia, bipolar disorder or depression associated with bipolar disorder. It indicated caution in use of this medication in the elderly or those with debility.			

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Review of Resident #7's Minimum Data Set (MDS) assessment, dated 3-4-11, indicated the Care Area Assessment Summary (CAAS) had triggered for the development of a care plan related to the area of psychotropic drug use. The CAAS indicated in "Problem Area 17, Psychotropic Drug Use" that a care plan had been initiated and updated as needed, as of 3-2-11.

Review of Resident #7's care plan indicated for the problems identified as, "Anxiety" and "Depression," each had the same intervention indicated, "Administer meds per order," indicated as written on 6-15-11. The care plan indicated no further information in regard to type or name(s) of medication or any specific side effects related to these medications.

D. Resident #32's clinical record was reviewed on 8-29-11 at 12:55 p.m. Her diagnoses included, but were not limited to depression, chronic anxiety, insomnia, atrial fibrillation (irregular heart beat), irritable bowel syndrome and GERD (gastroesophageal reflux disease.)

Review of the physician's orders for medications for Resident #32 indicated the psychotropic medications Valium 2 mg (milligrams) daily at 11:00 a.m. and

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	Valium 2 mg every 8 hours as needed, Ambien 10 mg daily at bedtime and Zoloft 25 mg daily at bedtime. None of these medications indicated for what purpose they were to be given. The "Nursing Spectrum Drug Handbook 2010" indicated Valium is indicated for anxiety (page 339); Ambien is indicated for insomnia (page 1250); Zoloft is indicated for depression (page 1073.) Review of Resident #32's Minimum Data Set (MDS) assessment, dated 4-18-11, indicated the Care Area Assessment Summary (CAAS) had triggered for the development of a care plan related to the area of psychotropic drug use. The CAAS indicated in "Problem Area 17, Psychotropic Drug Use" that a care plan had been initiated and reviewed as needed, as of 4-14-11. Review of Resident #32's care plan for the problem of "Chronic anxiety AEB [as evidenced by] restlessness," indicated as 4-7-11 without a revision or review date, indicated an intervention for this to be "meds [medications] as ordered." The care plan indicated no further information in regard to type or name(s) of medication or any specific side effects related to these medications. Another care plan entry, dated 4-11-11 without a revision or review date, indicated a problem identified as			

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	"c/o [complains of] not sleeping at night-dx [diagnosis of] insomnia." An intervention indicated for this problem is indicated as "meds as ordered." The care plan indicated no further information in regard to type or name(s) of medication or any specific side effects related to these medications. In interview with the Assistant Director of Nursing (ADON) and RN ## 1 on 9-2-11 at 10:50 a.m., the ADON indicated "the care plan doesn't appear fully developed" for the psychotropic medications of Resident #7. RN ## 1 indicated she reviews the resident's medication list, "but especially with new residents, we initially care plan for their diagnoses." In interview with the Director of Nursing on 8-30-11 at 9:58 a.m., he indicated the facility's policy on care plans "is to write a care plan for each diagnosis." He indicated in reference to Resident #32's care plan, "Can't say it looks like there's much here in regards to any of the psych [psychotropic] meds. The care plans are not quite there yet." A policy entitled, "Careplans [sic]" with an activation date of 1/07 was provided on 8-30-11 at 1:20 p.m. by the Corporate Nurse. This document indicated, "Each resident will have a plan of care to			

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	identify problems, needs and strength [sic] that will identify how the interdisciplinary team will provide care...All areas of concern will be addressed by the interdisciplinary team. The documentation is to be in the departmental notes and/or on the care plan...For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable (i.e., walk from the nurses [sic] station to room by the next review of care plan). Staff approaches are to be developed for each problem/strength need. When possible, more than one discipline per approach is to be documented on the care plan or ALL disciplines are responsible for that approach. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition. Each department's notes are to reflect a review of all appropriate care plan goals and approaches." 3.1-35(a) 3.1-35(b)(1)			

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation, and interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents in that one resident sustained second degree burns after hot beverage spills. This affected 1 of 4 residents reviewed for potential for accidents related to burns in a sample of 16. (Resident #37) Findings include: Resident # 37's record was reviewed on 9/1/11 at 2:45 p.m. The record indicated Resident #37 was admitted with diagnoses that included, but were not limited to, atrial fibrillation (heart arrhythmia), coronary artery disease, prior heart attack, chronic low blood pressure, and aortic stenosis. A quarterly Minimum Data Set Assessment (MDS) dated 6/9/11 indicated Resident #37 was severely cognitively impaired, has continuous behavior of delirium and disorganized thinking, was independent with eating after set up, had no impairment in range of motion in	F0323	**F323 Free of Accident Hazards/Supervision/Devices** The facility's intent is to provide adequate supervision and assistive devices to prevent accidents. **Actions Taken:** 1. In regards to Resident # 37: Resident receives hot liquids only with supervised meals and activities, 1 on 1 supervision during consumption until cup is empty, protective apron on during consumption of hot liquids. **Others Identified:** 100% audit of residents of all residents for safety with hot liquids. No other resident's identified. **Measures Taken:** All staff re-in-serviced on Hot liquid safety, assessments, interventions, and prevention of burns; staying with high risk residents while consuming hot beverages, etc. Dining Room Supervisor will monitor during meals for One on One supervision of resident while consuming hot beverages. Activities Director will monitor during activities for One on One supervision of resident while consuming hot beverages.	09/25/2011

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	upper or lower extremities, and used a wheelchair for mobility. Nurse's notes indicated: - 8/18/11 at 3:10 p.m.: "...CNA reported res (resident) spilt hot tea on self. res took to RM (room) & skin checked, tea on clothing protector & blue jeans. Skin normal color, no raised or O/A (open areas)...." - 8/18/11 at 5:00 p.m.: "...nurse reported to writer res spilt hot coffee on self removed lid of travel mug res was sitting at table in main dining room. Cool compress applied, area reddened. [no] O/A or raised area...dietary notified of N.O. Kennedy cup for hot liquids res clothes [changed] and returned to dining room for supper." - 8/18/11 at 5:50 p.m.: "res in room, writer went to check on reddness (sic)...Res noted to have small blisters on left lower abd. (abdomen)...." - 8/19/11 at 11:30 a.m.: "Resident observed to self remove lid from hot beverage container & has [increased] aggitation (sic) during attempts to assist [with] carrying of hot beverages when he wants to leave table [with] beverage. Resident is grossly demented & HOH (hard of hearing) - has poor ability to recognize safety needs & interventions. Will have therapy eval & will use heat protectant apron when resident insistant		**How Monitored:** Dietary Director/Designee will audit/review temperature of hot water carafes, and maintain a log, prior to leaving the kitchen to ensure a temperature of 130 degrees for three months and weekly thereafter. CEO/Designee will review monitoring tools for meals and activities daily for compliance with supervision with consumption of hot beverages. All monitoring tools will be reviewed in monthly QA meeting and quarterly QA meeting with Medical Director.	

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	155233	A. BUILDING 00 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN47006

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	(sic) on traving (sic) [with] hot Beverage...." - 8/19/11 at 11:40 a.m.: "Res. refused cold compress to burn area, states "I don't want it." Res. in MDR (main dining room) [with] apron on. Noted to take lid off of Kennedy cup, filling it [with] cold water past fill line. Stated "the tea is always too hot so I add cold water." Explained to res. not to take lid off and importance of fill line. Res. [not] cooperative." - 8/19/11 at 12:20 p.m.: "Res was given hot tea in Kennedy cup per res request, staff had made tea & added sweeter & removed tea bag. Res was observed removing Kennedy cup lid res. had a used tea bag he had kept & he added that to his cup...." - 8/19/11 at 2:00 p.m.: "New order rec'd - cleanse blistered area to (L) [lower] abd [with] NS (normal saline), apply Silvadene cream then non adherent drsg (dressing), [change] bid (twice a day) & prn (as needed) until healed...." - 8/20/11 at 4:00 p.m. "8A late entry - At breakfast Res. removed lid from Kennedy cup containing coffee that was prepared for him by staff, he stated he wanted cold water added to it, cold water was added & Res. reminded not to remove lid on cup for safety (sic), 2-3 min after reminder Res. removed lid once again...." - 8/27/11 at 1:00 a.m.: "(L) lower			

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	abdomen & upper thigh [with] open area following burn on 8/18 from spilling hot beverage on self. Drsg [change] as per order. Res denies pain." Care plans dated 8/19/11 indicated the care plans were updated as follows: "Problem/Need: HAS PREFERENCE TO CARRYING HOT BEVERAGES WHILE UP IN W/C WITH HX (history) OF SELF REMOVAL OF LIDS, RECURRENT COFFEE SPILL WITH BURN, RES HAS POOR ABILITY TO RECOGNIZE SAFETY WITH HOT BEVERAGES AEB (as evidenced by) SELF REMOVAL OF LIDS" "Goal & Target Date: WILL HAVE NO FURTHER SPILLS OF HOT BEVERAGES WHICH RESULT IN INJURY TNR (through next review)" "Approaches: KENNEDY CUP FOR HOT LIQUIDS, ENCOURAGE TO SIT AT TABLE WHEN DRINKING HOT BEVERAGES, ENC (encourage) TO PERMIT STAFF TO CARRY HOT BEVERAGE FOR HIM, ENC TO WEAR HEAT PROTECTANT APRON WHEN CARRYING HOT BEVERAGES HIMSELF, THERAPY ADVISED AND WILL SCREEN 8/19/11, NOTIFY SS (Social Services) PRN, FOLLOW UP WITH DR/FAMILY PRN, SKIN TREATMENT PRN AS ORDERED, SKIN ASSESSMENT IMMEDIATELY			

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	AFTER SPILL EVENT." "Problem/Need: SELF REMOVES LIDS TO REUSE TEA BAG EVEN THOUGH BEVERAGE IS ALREADY MADE, NONCOMPLIANT WITH USING KENNEDY CUP/APRON AEB RES NOTED TO UNSCREW THE LID, TAKE A DRINK, AND SCREW THE LID BACK ON" "Goal & Target Date: WILL NOT REMOVE LIDS TNR, RES TO REMAIN SAFE IN HIS OWN ENVIRONMENT TNR" "Approaches: ENC RES TO USE KENNEDY CUP/APRON, STAFF TO MAKE RESIDENT'S TEA WITH 2 TEA BAGS AND REMOVE THE BAGS BEFORE SERVING, ENC RESIDENT TO ALLOW STAFF TO ADD SWEETNER TO HIS BEVERAGES, NOTIFY SS PRN." An "INCIDENT DOCUMENTATION AND INVESTIGATION TOOL" dated 8/18/11 at 3:00 p.m. indicated Resident #14 was propelling self in his wheelchair in the hallway and spilt hot tea on himself. The first intervention after this incident was to have the resident not hold tea and propel himself in the wheelchair. An "INCIDENT DOCUMENTATION AND INVESTIGATION TOOL" dated 8/18/11 at 4:50 p.m. indicated this			

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resident was sitting in the dining room and had spilt the coffee he was drinking while awaiting supper. The first interventions after this incident was to encourage resident to allow them to prepare his hot beverage by adding sweetener, and to encourage to use the heat protectant apron.

A care plan dated 8/31/11 indicated a Problem/Need/Concern for: "Resident has demonstrated poor safety awareness AEB removing secured lids from warm beverages. Goal: Resident will continue to enjoy warm beverages without injury TNR. Nursing: 1. Resident to be provided with warm beverages with meals and supervised activities. 2. Staff to supervise resident with all warm beverages. 3. Staff to ask resident if all warm beverages are at temperature resident enjoys. 4. Resident to wear water resistant clothing protection and use Kennedy cup when drinking warm beverages."

On 8/31/11 at 12:25 p.m., with the Director of Nursing, Resident #14 was observed in the main dining room. He was seated in a wheelchair at a table by himself with a heat protectant apron on the front of his clothes from chin to knees. Resident #14 then removed the apron, folded it and placed it on the table. Social

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	Services poured hot water from the insulated carafe into a Kennedy cup, added sugar, put the tea bag in and dunked it a few times, then snapped the lid on and gave to Resident #14. The heat protectant apron was placed back on the resident. The Activity Director was observed to sit at the table with the resident after the resident was given the Kennedy cup. The burns on Resident #14's left abdomen and left upper thigh were observed on 9/1/11 at 12:25 p.m. with LPN #2. Resident #14 was reclined in a recliner in his room. The burned area on the lower left abdomen was open, moist looking, tan in color, and approximately 3 inches by 2 inches in size. The burned area on the upper left thigh was also tan in color, moist, and approximately 4 inches by 2 inches in size. During an interview on 9/1/11 at 12:18 p.m., the Director of Nursing indicated, on a written document, further corrective actions to ensure no other residents are affected by hot liquid burns. These include: "1.) Have contacted vendor for evaluation/adjustment of coffee machine. 2.) Temperature taken of Carafes liquids prior to serving Res. for appropriate warmth for 3 months. 3.) Re-assess all res. receiving hot liquids for safety. 4.)			

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	[Resident's name] will receive liq.'s (liquids) only [with] meals & activities. Staff member will be 1 on 1 til (sic) cup is empty. 5.) Heating Device removed from kitchen. Coffee/Hot Water will go directly from Coffee Pot to Carafes. 6.) Each res. identified as a risk for burns will have the appropriate assistive decides in place, i.e. Kennedy cup; traveler's mug; water resistant clothing protector." A Policy and Procedure for "INCIDENT DOCUMENTATION AND INVESTIGATION" was provided by the Administrator on 8/29/11 at 12:45 p.m. The policy indicated, but was not limited to: "POLICY: All incidents involving resident care will be investigated and documented on the Incident Documentation and Investigation Tool to enable the facility to evaluate the care given to residents, to assist in prevention of incidents, and evaluate intervention given in the event of an incident. An "incident" is any occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Incidents will be analyzed for trends or patterns to enable the facility to enhance preventive measures to reduce the occurrence of incidents....." A Policy and Procedure for "Serving Food			

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	and Beverages" was provided by the Administrator on 8/31/11 at 12:54 p.m. The policy indicated, but was not limited to: "Guideline: Staff shall follow the guidelines below when preparing and serving hot beverages and food. Procedure: 1. Foods shall be served at the following temperatures to ensure a safe and appetizing dining experience...Hot Beverages 130 [degrees] F (Fahrenheit) to 165 [degrees] F...." On 9/1/11 at 9:05 a.m., the Corporate Nurse Consultant indicated they had a coffee maker that maintained the coffee at the high temperature and they removed it from dietary. Staff are now to use water from the insulated carafe and check the temperature at the dietary window before serving it to Resident #14 at each meal. On 9/1/11 at 3:54 p.m., the Corporate Nurse Consultant indicated staff began sitting with Resident #14 with each meal until he is finished with his coffee or tea, they will do a hot liquid assessment with each resident to identify potential residents who could be affected by hot liquids, and they will serve hot liquids at no higher than 130 degrees for dementia residents. The Corporate Nurse Consultant also indicated the facility "will forever have the staff sit with" Resident #14.			

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	3.1-45(a)(1) 3.1-45(a)(2)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			

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	Based on interview and record review, the facility failed to conduct behavioral monitoring of Resident #7 prior to initiation of psychotropic medications and during the use of psychotropic medications. This deficient practice affected 1 of 9 residents reviewed for psychotropic medications in a sample of 16. (Resident #7) Findings include: Resident #7's clinical record was reviewed on 8-30-11 at 10:22 a.m. His diagnoses included, but were not limited to dementia, middle cerebral artery cerebrovascular accident (stroke), hypertension (high blood pressure), depression and anxiety. A review of Resident #7's medication orders indicated current physician orders for the psychotropic medications of Zyprexa 2.5 mg (milligrams) twice 9:00 a.m. and 9:00 p.m., of Seroquel 50 mg twice daily at 9:00 a.m. and 9:00 p.m., of Seroquel 25 mg daily at bedtime at 9:00 p.m., to be given with Seroquel 50 mg and Celexa 40 mg daily at 9:00 a.m. The Zyprexa was indicated to be used for depression; the Seroquel did not have a specific indication for its use; the Celexa was indicated to be used for depression and anxiety. The "Nursing Spectrum	F0329	**F329 Drug Regimen is free from unnecessary drugs.**It is the intent of this facility to conduct behavioral monitoring of all residents prior to initiation of psychotropic medications and during the use of psychotropic medications. **1. ACTIONS TAKEN:** a. In regards to Resident # 7: a behavior monitoring record was implemented for all psychotropic medication, with the appropriate medications identified, appropriate behaviors being tracked, and interventions to attempt prior to administration and during the use of psychotropic medications. **2. OTHERS IDENTIFIED:** a. 100% audit of all residents with routine and/or prn psychotropic medications for the appropriate behavior tracking tools, interventions, and documentation. This would affect all residents on antipsychotropic medications. **3. MEASURES TAKEN:** a. In-service for all licensed staff for antipsychotropic medications, appropriate interventions for behaviors, appropriate tracking of behaviors, appropriate documentation of behaviors, attempts of reductions during the use of antipsychotropic medications. **4. HOW MONITORED:** a. The IDT will review all behavior programs during weekly behavior meeting for appropriate tracking and	09/25/2011

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	Drug Handbook 2010" (pages 1007-1009) indicated Seroquel is indicated for use in persons with diagnoses of schizophrenia, bipolar disorder or depression associated with bipolar disorder. It indicated caution in use of this medication in the elderly or those with debility. Review of Resident #7's clinical record indicated an absence of any behavioral monitoring tool. In interview with the Social Services Designee (SSD) on 9-1-11 at 6:20 p.m., she indicated, "The only behavior tracking I have on [name of Resident #7] is what I did on August 17th [2011.] All I have is for August 17th." A copy of a document entitled, "Behavior Monitoring," was provided by the SSD during the interview for Resident #7. In interview with the SSD on 9-1-11 at 10:45 a.m., she indicated she had been having problems with the nursing staff filling out and completing the behavior monitoring tool. She indicated she was unsure why the behavioral monitoring tool was not being utilized by the nursing staff. She indicated it seemed like the nursing staff "were either unsure or uncomfortable filling out the forms." She indicated this particular tool had been instituted in January 2011. The SSD provided a copy of a document entitled, "Action Plans." She indicated, "Here is		documentation. This will be an on-going process. b. SSD/Designee will monitor all residents utilizing routine or prn medications for appropriate behavior programs and tracking of behaviors weekly. This will be an on-going process. c. CEO/Designee will review all audits weekly during QA meeting; monthly during QA meeting; and quarterly during QA meeting with the Medical Director.	

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	my action plan for behavior monitoring." She indicated she had recently been working with a Social Services consultant and she had scheduled an inservice for staff for September 8 and 9, 2011. This document indicated the focus as "Behaviors." The corrective actions indicated were, "Inservice all staff & educate in regards to behaviors [sic] management program, referral for new behaviors & current tracking for identified behaviors, and the importance for all staff in reporting all behaviors and monitoring all behaviors." "Evidence of Improvement" indicated "Better tracking of behaviors and to ensure appropriate reduction or increase of meds [medications] and to ensure all appropriate interventions are in place." The SSD provided a copy of a policy entitled, "Behavior Program Policy and Procedure," on 9-1-11 at 5:42 p.m. This policy had a revision date of 11-10. This policy indicated, "1. Policy criteria will be used to identify residents that will be included in the behavior program. 2. Form BP101 (Referral/Assessment/Determination) will be completed for residents identified in Step 1. An Evaluation of New or Worsening Behavior form (BP102) shall be completed when the observed behavior is new or worsening; as determined			

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	necessary by the IDT [Interdisciplinary Team.] After initial program implementation, new referrals may be submitted to the social services department by all staff at any time. The social services department will review residents upon admission to determine if they have an order for psychoactive medication. If so, social services will complete the referral. The IDT will review all referrals to determine if residents meet policy criteria for inclusion in the program and to determine the necessary course of action...3. Care plans will be developed to address mood, behavior and other psychiatric symptoms exhibited by residents in order to reduce or eliminate these problems. Alternative interventions will be attempted prior to the use of PRN [as needed, not routine] psychoactive medications...Approaches will focus on prevention and how to intervene should symptoms occur. 4. Care plans will be used to prepare behavior monitoring records (BP103) for those residents who require monitoring. Behavior monitoring records will be updated when changes are made to the care plan. Behavior monitoring records will be placed in a location accessible to all staff...5. Staff will be trained to assure they understand the behavior program purpose, policy and procedure..."			

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	3.1-48(a)(3) 3.1-48(b)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to ensure the kitchen range hood, the window, and the window air conditioner in the kitchen were routinely maintained. This had the potential to affect 78 of 79 residents that received meals from the facility kitchen. Findings included: During the initial dietary tour on 8/29/2011 at 10:22 A.M. with the medical records/LPN, the dietary manager was not present, observation of the window above the 3 compartment sink in the kitchen was very dirty, with greasy dust and cobwebs. The window air conditioner in the above window was very dirty with a built-up of grease and a moderate amount of black dust on the front of it. The range hood above the stove was greasy with a moderate amount of black dust on it and 2 red knobs on the stove had a light amount	F0371	**F371 – FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** It is the intent of this facility for the kitchen range hood, the window, and the window air conditioner in the kitchen are routinely maintained. **1. ACTION TAKEN:** A. The kitchen range hood and knobs have been cleaned. B. The window has been cleaned and has no grease, dust, or cobwebs.. C. The window air conditioner has been cleaned and is free of grease and dust. **2. OTHERS IDENTIFIED:** A. There was no negative outcome for any resident; although the potential was there.	09/25/2011

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	of black dust on each of them. On 8/31/2011 at 11:30 A.M., during the meal preparation observations, observation of the range hood included a greasy yellowish brown residue with a moderate amount of black dust present on the right side of the range hood and a light amount of black dust with a greasy yellow residue present on the left side of the range hood. During an interview with the Dietary Manager on 8/31/2011 at 11:45 A.M., she indicated that maintenance had always cleaned the range hood and she wasn't sure, but she thought it was maintenance that would clean the air conditioner, and the window in the kitchen due to the need for a ladder to complete the tasks. "I was not told that it was my responsibility to clean them when I started to work as the Dietary Manager in May of this year." On 8/31/2011 at 3:45 P.M.,in an interview with the Administrator regarding who is responsible for the cleaning of the range hood, the air conditioner, and the window above the 3 compartment sink in the kitchen. He indicated that it should be the maintenance department, but he would call and check with the Maintenance Director, as he is off at this time. The Administrator returned at 3:50 P.M.		**3. MEASURES TAKEN:** A. All Dietary Staff were in-serviced on appropriate cleaning and the schedule for cleaning. B. Maintenance Department in-serviced on Importance of keeping range hood clean. **4. HOW MONITORED:** A. CEO/Designee will do random audits weekly for effectiveness of corrective action. B. Dietary Services Manager will monitor daily for compliance with appropriate cleaning and the cleaning schedule. C. The Maintenance Director/Designee will monitor weekly for the cleanliness of the range hood.; and clean as needed. D. CEO/Designee will review all audits in monthly QA meeting and in quarterly QA meeting with the Medical Director..	

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	and stated, "I will call the Maintenance Director in the morning for you to talk with him to obtain answers to your questions". During an interview via the telephone with the Maintenance Director on 9/1/2011 at 9:05 A.M., he stated "the range hood filters were last cleaned 9/2010, as we clean them annually per supplier recommendations. I believe they are due to be cleaned on 9/20/2011". "The air conditioner is cleaned monthly and the kitchen is supposed to clean the windows." [Name of company] comes annually to clean the range hood filters and the report from them should be in the maintenance manual". Review of the Exhaust Removal System's Report, received from the Administrator on 9/1/2011 at 9:45 A.M., indicated "service date 9-9-2010, cleaned exhaust system, next due 9-2011, system access sufficient, system's condition (load) med [medium?] , cleaning frequency appears adequate". Review of "The Waters Weekly PM[preventive maintenance] Checklist" for August 2011 provided by the Administrator on 9/1/2011 at 9:45 A.M., indicated the hood filters were checked on 8/5/11, 8/12/11, 8/18/11, and 8/26/11. Review of the July 2011 weekly preventive maintenance, indicated the ...			

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	155233	A. BUILDING 00 B. WING	09/02/2011

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	and window AC's (clean and dust free) on 7/21/11 and clean all kitchen ... intake/discharge vents." Observation of the range hood, the window, and the air conditioner in the kitchen on 9/1/2011 at 9:45 A.M., still had a yellowish brown greasy residue and a moderate amount of black dust on them. 3.1-21(i)(1) 3.1-21(i)(2)			
F0387 SS=D	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on interview and record review, the facility failed to ensure timely physician visits in that one resident (Resident #32) did not receive a physician visit from the time of admission until more than 4 months later. This deficient practice affected 1 of 12 residents reviewed for timely physician visits in a sample of 16. (Resident #32.) Findings include:	F0387	**F387 FREQUENCY & TIMELINESS OF PHYSICIAN VISITS:** It is the intent of this facility to ensure timely physician visits. **1. ACTIONS TAKEN:** A. In regards to resident # 32, the resident was seen August 18th, follow-up by the CEO will occur one week prior to next required visit to verify compliance. **2. OTHERS IDENTIFIED:** A. 100 % audit of all residents for timeliness of physician visits. No other residents were identified. **3.**	09/25/2011

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	Resident #32's clinical record was reviewed on 8-29-11 at 12:55 p.m. Her diagnoses included, but were not limited to depression, chronic anxiety, insomnia, atrial fibrillation (irregular heart beat), irritable bowel syndrome and GERD (gastroesophageal reflux disease.) The clinical record review indicated Resident #32 was admitted on 4-5-11. The only physician visit documented was dated 8-18-11. This indicated a lapse of 155 days between admission and the initial face-to-face visit with the physician. In interview with Resident #32 on 8-31-11 at 1:50 p.m., she indicated she had seen her physician only one time since being admitted to the facility. She indicated this visit occurred, "just a few weeks ago." In interview with the Medical Records staff person #3 on 8-30-11 at 2:23 p.m., she indicated Resident #32 had been seen by her physician only one time since admission. She indicated that date was 8-18-11. She indicated she had faxed the physician notifications of the need for a visit on 5-17-11, 5-30-11, 6-13-11, 6-29-11, 7-15-11 and 7-29-11. She indicated the resident had requested to be seen in the physician's office and when the nursing staff telephoned the physician's		**MEASURES TAKEN:** A. CEO held a meeting with the Medical Director in regards to the physician visits; if the physicians are not timely with their visits, the Medical Director will speak with the physician and see the resident if needed. **4. HOW MONITORED:** A. Medical Records/Designee to review all health records monthly and notify the physician within two weeks of the expected/required visit. Medical Director and CEO are to be notified one week prior to required visit if the primary physician has not met their obligation. This will be an on-going process. B. CEO/Designee will review all audits monthly with QA team and quarterly with Medical Director in QA meeting. .	

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	office to schedule an appointment, "the response from the doctor's office was that she would see her in the facility." She indicated the Medical Director was informed of the issue of the late physician visits at a QA (Quality Assurance) meeting on 7-27-11. In interview with the Medical Director on 8-31-11 at 9:40 a.m., he indicated he was notified of the late physician visit for Resident #32 at the July 2011 QA meeting. He indicated he did not realize the resident had not been seen since her admission in April. He indicated if he had realized how late the visit was, "I would have done something...like even see the resident [myself]." He indicated he followed up with the physician's office and "found out she was planning on coming in [to the facility] in August." The facility's Corporate Nurse indicated on 8-30-11 at 1:20 p.m. the facility does not have a written policy on frequency of physician visits. 3.1-22(d)(1) 3.1-22(d)(2)			

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F0428 SS=D	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Based on record review and interview the facility failed to act upon a resident pharmacist recommendations in a timely manner. This affected 1 of 13 in a sample of 16 and 1 of 1 in a supplemental sample of 1. (Resident # 7 and Resident # 3) Findings included: 1. Review of Resident #3's record on 9/1/2011 at 3:40 P.M., indicated she was admitted with, but not limited to depression, dementia, hypertension, and angina. The resident had an order for Lotrel 5-20 mg capsule once daily for hypertension that she had received since 6/5/2007. Review of the "Consultant Report, The Waters of Batesville, LLC...PRN Pharmaceutical Services, Inc., July 1, 2011 through July 31, 2011", comments: Resident's name "takes Benazeprel and does not have a Creatinine/electrolyte evaluation documented in the resident record within the previous 6 months," with a recommendation date: 7/25/2011,	F0428	**F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON** It is the intent of this facility to act upon all pharmacist recommendations in a timely manner. **1. ACTIONS TAKEN :** a. In regards to Resident # 3: a BMP (basic metabolites profile) was drawn. b. In regards to Resident # 7: a physician's order for the recommended labs was received and the fasting lipid panel, ALT, and BMP were drawn by the lab. **2. OTHERS IDENTIFIED:** a. A 100% audit of the pharmacy recommendations for the last three months will be completed. Any identified recommendations will be forwarded to the physician for a response. **3. MEASURES TAKEN:** a. All licensed staff were in-serviced on the importance of reviewing pharmacy recommendations and forwarding the recommendations to the physician, and follow-up for a response in one week.	09/25/2011

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	"Please consider monitoring a BMP [basic metabolic panel] on the next convenient lab day." The Physician's response, "Okay for BMP q [every] 6 months", dated 8/18/2011. In an interview with the ADON[Assistant Director of Nursing] on 9/2/2011 at 2:15 P.M., regarding what the expectation would be for obtaining a BMP ordered by the resident's physician from a pharmacy recommendation. She replied, "the next lab day on Wednesday's, but within a week." Interviewed regarding results of BMP scheduled for Resident #3, the ADON replied, "there is", but upon looking in Resident # 3's record she indicated that she did not find any labs for a BMP, but she had an order written for a BMP to be completed on the next lab day. B. Resident #7's clinical record was reviewed on 8-30-11 at 10:22 a.m. His diagnoses included, but were not limited to dementia, middle cerebral artery cerebrovascular accident (stroke), hypertension (high blood pressure), depression and anxiety. Review of a document entitled, "Consultation Report," dated 6-9-11, indicated the facility's pharmaceutical services recommended, "Please consider		**4. HOW MONITORED:** a. DON/Designee will review all pharmacy recommendations and forward to the physician by the end of one week. The DON/Designee will follow-up in a minimum of one week for a response from the physician. This will be an on-going process. b. The CEO/Designee will review all recommendations in the QA meeting monthly and in the quarterly QA meeting with the Medical Director.	

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	monitoring a fasting lipid panel [lab test for blood fats], ALT [lab test for liver function] and a BMP [lab test for basic metabolic elements] on the next convenient lab day and at least every twelve months thereafter." Review of the clinical record since the date of the recommendation failed to indicate the recommendation had been forwarded to the resident's physician for review and failed to indicate these laboratory tests had been conducted. In interview with the Director of Nursing on 9-2-11 at 9:35 a.m., he indicated he had yet to forward the recommendations to the physician. This would be almost 2 months, or 54 days, after the recommendation was made by the pharmacist. In interview with the Assistant Director of Nursing on 9-2-11 at 10:50 a.m., she indicated, "I would have thought the labs should have been able to be gotten at the next scheduled lab day. The lab comes once a week for non-emergency or stat labs. For a stat lab they can come right away." A policy entitled, "Consultant Pharmacist Responsibilities," with a revision date of 12-1-06, was provided by the Director of Nursing on 9-2-11 at 12:03 p.m. This			

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	policy indicated, " The consultant pharmacist shall be responsible for the general supervision of the facility ' s pharmaceutical services. These responsibilities include, but are not limited to ...Drug Regimen reviews for all residents as required ...This Drug Regimen Review report must be forwarded by the facility to the appropriate physician. The physician must provide a written response to the facility in a timely manner ... " 3.1-25(i)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on interview and record review, the facility failed to ensure 1 resident's PPD/TB (tuberculosis) test results were properly read and documented. This deficient practice affected 1 of 13	F0441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** It is the intent of this facility for all resident's PPD/TB test results properly red and documented. **1. Action Taken:**	09/25/2011

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	residents reviewed for PPD/TB test results in a sample of 16. (Resident #7) Findings include: Resident #7's clinical record was reviewed on 8-30-11 at 10:22 a.m. His diagnoses included, but were not limited to dementia, middle cerebral artery cerebrovascular accident (stroke), hypertension (high blood pressure), depression and anxiety. It indicated he was admitted to the facility on 2-23-11. Review of a document entitled, "Immunization Record," indicated Resident #7 had received a PPD/TB test on 2-3-11 at another facility. This document did not indicate the results of this test. Another PPD/TB test was indicated to have been administered by the other facility on 2-23-11 and to have been read by a facility staff nurse on 2-26-11 with the results documented as 0 mm (millimeters.) This resulted in only one PPD/TB test with a documented result and no other documentation of prior PPD/TB testing. In interview with the Director of Nursing on 9-1-11 at 8:57 a.m., he indicated, "It looks like on [name of Resident #7]'s PPD we should have either tracked down the results or given another TB test."		In regards to Resident # 7: The TST (Tuberculin Skin Test) Was re-administered and read in a timely manner; then documented in the health record. **2. Resident's Identified:** 100% audit was completed for all Residents. No other residents were identified. **3. Measures Taken:** All licensed nursing staff in-serviced on following the policy/proceduresfor infection control as it relates to Tuberculosis, appropriate administrations and documentation of the results. **4. How Monitored:** A. DON/Designee will audit all new admissions for appropriate administration and documentation of the initial TST (Tuberculin Skin Test) and will follow-up with a 2 nd audit for the completion and documentation of the 2 nd step TST to ensure continued compliance. This will be an on-going process. B. CEO/Designee will review audits weekly during QA stand-up meeting; and will review with QAA Committee and the Medical Director quarterly.	

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	A policy entitled, "Tuberculosis Surveillance," with an activation date of 1-07, was provided by the Corporate Nurse on 8-30-11 at 1:20 p.m. This policy indicated, under the heading, "Booster Phenomenon: Two step testing can be used to reduce the likelihood that a booster reaction is misinterpreted as a new infection. Two step testing should be performed on all new HCW's [healthcare workers] and residents who have an initial negative PPD result at the time of employment/admission and have not had a documented negative PPD test during the 12 months preceding the initial test. A second test should be performed 1-3 after the first test." 3.1-18(e) 3.1-18(f)			

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F0514 SS=E	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview the facility failed to ensure complete and accurate documentation in clinical records as indicated by: (1) A physician history and physical had no date and no name, no date for urinalysis, no initial PPD results documented, and recapitulation orders did not identify the resident's code status. (Resident # 7) (2) Incomplete BM[bowel movement] record. (Resident # 32) (3) One loose page of care plan with no date and no name of resident. (Resident #40) (4) Incorrect identification of a psychoactive medication in the Social	F0514	**F514 CLINICAL RECORDS:** The intent of the facility is for all residents to have a complete and accurate health record. **1. ACTIONS TAKEN :** A. In regards to Residents # 7: The History and physical was dated for the day completed by the physician and the residents name was placed on the form. The Urinalysis was dated; the TST was administered, red, and documented appropriately and the Code Status was clarified and added to the physicians' order sheet. B. In regards to Resident # 32: The residents' bowel record will be monitored daily for completion. C. In regards to Resident # 40: The loose care plan page was dated and the residents name was placed on the document. D. In regards to Resident # 47: the correct psychoactive medication was	09/25/2011

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	Services documentation. (Resident #47) This affected 4 of 16 in a sample of 16. (Resident #7, 32, 40, & 47) Findings included: 1. Review of the record for Resident #40 on 9/1/2011 at 10:30 A.M., indicated the resident was admitted with, but not limited to dementia with behavioral disturbance & paranoia, hypertension, diabetes, coronary artery disease, anemia, and arthritis. Review of the care plans for Resident # 40 on 9/1/2011, indicated one loose page that had no name and no date on it. The other care plans were dated as reviewed on 6/29/2011 by facility staff. 2. The record review for Resident # 47 on 8/29/2011 at 2:03 P.M., indicated the resident was admitted with, but not limited to Ischemic Thoracic Myelopathy, diabetes, myasthenia gravis, lower extremity paraparesis, depression, suicidal ideation, hypertension, and prostate adenocarcinoma.		documented in the Social Services section of the health record. **2. OTHERS IDENTIFIED:** A. 100 % audit of all residents health records to identify any/all concerns related to an inaccurate/incomplete health record. This would affect all residents. **3. SYSTEMS IN PLACE:** A. In-Service all licensed staff in regards to the inmportance of a complete and accurate health record including: Resident name on all forms/paperwork; completion of all documentation to include the name of the resident and the date concerned; accuracy of lab requisitions; completion of TST and appropriate documentation; accuracy of health record in regards to medication utilized; loose papers with no resident name or identifier, etc. **4. HOW MONITORED:** A. Medical Records/Designee will audit all new admissions for appropriate documentation of initial TST (Tuberculin Skin Test) within 24 hours of admission and appropriate	

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	Medications included, but not limited to Cymbalta 60 mg once daily for depression, Metformin HCL 1,000 mg two times daily with meal, proscar 5 mg once daily, Glipizide 5 mg once daily with meal, and Prednisone 10 mg once daily. A social services assessment dated 7/21/2011, completed by the facility Social Services Director, indicated "psychoactive medications & diagnoses to support: Celexa 20 mg 1 tab 1 x day - depression TNR[through next review]". "Res[resident] just had recent Dx[diagnoses] of Cancer." Resident #47 received Cymbalta 60 mg once daily since 7/18/2011. Interview with the Social Services Director on 9/2/2011 at 2:45 P.M. regarding her assessment on 7/21/2011, she stated, "I'm sorry I didn't realize I had put Celexa on that assessment, he was on the Cymbalta then." The Social Services Director marked a single line through Celexa information wrote error above, initialed and dated 9/2/11.		follow-up with 2 nd step. B. Medical Records/Designee will audit all health records to ensure there are no loose paperwork; applying reinforcers as needed. C. D.O.N./Designee will audit all lab orders/requisitions for appropriate completion; D. All Department Managers will monitor/audit there section of the health record for accurate and complete documentation. E. CEO/Designee will review all audits as completed and will review in the weekly QA meeting; monthly in the QA meeting; and quarterly in QA meeting with the Medical Director. This will remain an on-going audit.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	C. Resident #7's clinical record was reviewed on 8-30-11 at 10:22 a.m. His diagnoses included, but were not limited to dementia, middle cerebral artery cerebrovascular accident (stroke), hypertension (high blood pressure), depression and anxiety. Review of Resident #7's clinical record included a document entitled, "Admission History and Physical Examination." This document did not indicate any resident's name on the document, nor did it have a date indicated as to when the documented was completed. Review of Resident #7's clinical record indicated a physician's telephone order form was present without a date, only a time of 1:00 p.m. which indicated, "UAX hematuria [urinalysis for hematuria/blood in the urine]." Review of Resident #7's clinical record included a document entitled, "Immunization Record." This document indicated Resident #7 had received a PPD/TB (tuberculosis) test on 2-3-11 at another facility. This document did not indicate the results of this test. Review of Resident #7's monthly recapitulation (physician) orders for June, July and August 2011 did not indicate the	F0514	**F514 CLINICAL RECORDS:** The intent of the facility is for all residents to have a complete and accurate health record. **1. ACTIONS TAKEN :** A. In regards to Residents # 7: The History and physical was dated for the day completed by the physician and the residents name was placed on the form. The Urinalysis was dated; the TST was administered, red, and documented appropriately and the Code Status was clarified and added to the physicians' order sheet. B. In regards to Resident # 32: The residents' bowel record will be monitored daily for completion. C. In regards to Resident # 40: The loose care plan page was dated and the residents name was placed on the document. D. In regards to Resident # 47: the correct psychoactive medication was documented in the Social Services section of the health record. **2. OTHERS IDENTIFIED:** A. 100 % audit of all residents health records to identify any/all concerns related to an inaccurate/incomplete health record. This would affect all residents.	09/25/2011

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	resident's code status as either "Full Code" or "DNR" (Do Not Resuscitate.) D. #32's clinical record was reviewed on 8-29-11 at 12:55 p.m. Her diagnoses included, but were not limited to depression, chronic anxiety, insomnia, atrial fibrillation (irregular heart beat), irritable bowel syndrome and GERD (gastroesophageal reflux disease.) Resident #32's "Activities of Daily Living Documentation" forms were reviewed for 4-5-11 through 5-2-11, for 5-23-11 through, and one time period without a month listed, but the numeric dates of 2 through 23. These documents indicated there were no bowel movements, as indicated by a zero, for 4-7-11 until 4-11-11; for 4-26-11 through 5-2-11. For the document without a month listed, it indicated there were no bowel movements, as indicated by a zero, for the numeric dates of 3 until 7; for 10 until 14; and for 18 until 21. For the document, dated 6-20-11 through 7-17-11, there were unmarked/empty blocks for bowel movements for day shift on 6-28 and 7-8; for evening shift for 6-25, 6-26, 6-27, 7-1, 7-2, 7-3 and 7-5; for		**3. SYSTEMS IN PLACE:** A. In-Service all licensed staff in regards to the inmportance of a complete and accurate health record including: Resident name on all forms/paperwork; completion of all documentation to include the name of the resident and the date concerned; accuracy of lab requisitions; completion of TST and appropriate documentation; accuracy of health record in regards to medication utilized; loose papers with no resident name or identifier, etc. **4. HOW MONITORED:** A. Medical Records/Designee will audit all new admissions for appropriate documentation of initial TST (Tuberculin Skin Test) within 24 hours of admission and appropriate follow-up with 2 nd step. B. Medical Records/Designee will audit all health records to ensure there are no loose paperwork; applying reinforcers as needed. C. D.O.N./Designee will audit all lab orders/requisitions for appropriate completion; D. All Department Managers will	

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	the night shift for 6-25, 6-26, 6-30, 7-1, 7-2, 7-3 and 7-16. It indicated no bowel movements, as indicated by a zero or empty block, for 6-21 until 6-25. In interview with Resident #32 on 8-31-11 at 1:50 p.m., she indicated she normally has a bowel movement every day. She indicated the nurses "are good to check with me about my bowel movements every day." In interview with the Director of Nursing on 8-30-11 at 9:58 a.m., he indicated, "There are a lot of holes on the ADL sheet...At this point there's no way of her or us recalling if she had a BM [bowel movement] a month or two ago...Our policy is to look into it more closely by the third day with no BM." A policy entitled, "Medical Records," with an activation date of 4-06, was provided by the Corporate Nurse on 8-30-11 at 1:20 p.m. This policy indicated, "1. Each resident will have an active medical record. This resident record shall be kept current, complete, legible...2.b. Each record entry shall be written in ink or typed, shall be signed, dated and shall include the profession or title of the person making the entry." A policy entitled, "Telephone Orders,"		monitor/audit there section of the health record for accurate and complete documentation. E. CEO/Designee will review all audits as completed and will review in the weekly QA meeting; monthly in the QA meeting; and quarterly in QA meeting with the Medical Director. This will remain an on-going audit.	

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	with an activation date of 1-07 was provided by the Corporate Nurse on 8-30-11 at 1:20 p.m. This policy indicated, "The date ordered...must appear." A policy entitled, "Tuberculosis Surveillance," with an activation date of 1-07, was provided by the Corporate Nurse on 8-30-11 at 1:20 p.m. This policy indicated, "Document [results] on Resident Immunization Record in millimeters of induration." A policy entitled, "Completing Rewrites," with an activation date of 10-08, was provided by the Corporate Nurse on 8-30-11 at 1:20 p.m. This policy indicated, "The nursing facility is responsible for verifying the accuracy of all data on the rewrites [recapitulation orders]." A policy entitled, "ADL [Activities of Daily Living] Documentation" with an activation date of 11-07 was provided by the Corporate Nurse on 8-30-11 at 1:20 p.m. This policy indicated, "It is the responsibility of the Nursing Personnel to document ADL Care provided or declined daily...1. CNA's [Certified Nursing Assistants] will document ADL's provided or assisted daily on each shift...3. The charge Nurse [sic] of each shift is			

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	responsible for monitoring the documentation on each resident ADL sheet by the end of their shift." 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(f)(1)			
F9999		F9999	**F9999 FINAL OBSERVATIONS** It is the intent of this facility for all employees to have a health screeningand a TST (Tuberculin Skin Test)results and/or Chest X-ray or TB assessment documented in their employee file prior to first day of employment.. **1. Action Taken:** In regards to employees: No employee will start work until The TST (Tuberculin Skin Test), Chest X-ray and/or TB assessment, and A health screening have been completed. **2. Resident's Identified:** 100% audit was completed for all employees. No other employees were identified. **3. Measures Taken:** CEO, DON, BOM abd /business office staff in-serviced on following the policy/proceduresfor infection control as it relates to Tuberculosis, appropriate	09/05/2011
	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording, unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure			

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	the following: (1) At the time of employment, or within one (1) prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of testing of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record that includes the following: (A) a report of the preemployment physical examination. (B) reports of all employment-related health examinations. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 11 employees had a timely tuberculosis screening and a		administrations and documentation of the results and a health screeningprior to employment. **4. How Monitored:** A. BOM/Designee will audit all new employees for appropriate administration and documentation of the TST (Tuberculin Skin Test),and/or Chest X-ray with TB assessment, and the health screening prior to first work day to ensure continued compliance. This will be an on-going process. B. CEO/Designee will review all employee Files prior to first work day to ensure compliance CEO/Designee will review in weekly QA meeting; and will review with QA Committee and the Medical Director at quarterly meeting.	

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	timely health screening prior to employment. This deficient practice has the potential to adversely affect all residents. (Administrator) Findings include: Employee records were reviewed on 9/2/11 at 11:00 a.m. and included 11 employees hired within the past 120 days. The Administrator had a hire date of 8/23/11 and failed to have a tuberculosis screening upon hire, and failed to have a health screening (physical examination) upon hire. The "EMPLOYEE HEALTH EXAMINATION RECORD" for the Administrator indicated it had been completed and signed by a physician on 8/30/11 and the chest x-ray had been done on 8/30/11. On 9/1/11 at 4:30 p.m., the Administrator indicated he can't take the skin test (for tuberculosis) and always gets a chest x-ray, but his last chest x-ray would have been outdated. He also indicated he didn't have a risk assessment done, and he couldn't get in to get the physical or chest x-ray until 8/30/11. The Administrator indicated his first day to work in the facility was 8/23/11.			

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	A policy and procedure for "TUBERCULOSIS SURVEILLANCE" was provided by the Corporate Nurse Consultant on 8/30/11 at 1:20 p.m. The policy indicated, but was not limited to: "POLICY: All employees, residents and volunteers, will be screened for tuberculosis. RESPONSIBILITY: Administrator/Director of Nursing...3. Employees and volunteers must be tested prior to employment and annually thereafter...4. Complete the Resident and Employee Tuberculosis Screening Tool, if an employee/ volunteer has had a documented positive skin test in the past...." 3.1-14(t)(1) 3.1-14(t)(2) 3.1-14(t)(3)(A) 3.1-14(t)(3)(B)			